31A-30-101. Title.

This chapter is known as the "Individual, Small Employer, and Group Health Insurance Act."

Amended by Chapter 108, 2004 General Session

31A-30-102. Purpose statement.

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market;

(5) provide increased access for individuals and small employers to health insurance; and

(6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the Health Insurance Exchange created by Section 63M-1-2504.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with this chapter, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means a person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) (a) "Bona fide employer association" means an association of employers:

(i) that meets the requirements of Subsection 31A-22-701(2)(b);

(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;

(iii) that is organized:

(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation

interest or genuine organizational relationship unrelated to the provision of benefits; and

(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and

(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):

(i) how association members are solicited;

(ii) who participates in the association;

(iii) the process by which the association was formed;

(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;

(v) the powers, rights and privileges of employer members; and

(vi) who actually controls and directs the activities and operations of the benefit programs.

(5) "Carrier" means a person that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) another person providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.

(8) "Covered carrier" means an individual carrier or small employer carrier subject to this chapter.

(9) "Covered individual" means an individual who is covered under a health benefit plan subject to this chapter.

(10) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(11) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(12) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(13) "Index rate" means, for each class of business as to a rating period for

covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(14) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(15) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(16) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including fees or other contributions associated with the health benefit plan.

(18) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(19) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(20) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers, except as provided in Subsection (3); or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association, except as provided in Subsection (3);

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) short-term limited duration health insurance;

(b) federally funded or partially funded programs; or

(c) a bona fide employer association.

(4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if the ceding arrangements would result in less than 50% of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

(d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

(5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsections 31A-30-106(1) and 31A-30-106.1(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining

arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection (5) may not apply to an individual if the person participates in a Taft Hartley trust as an associate member of any employee organization.

(6) Sections 31A-30-106, 31A-30-106.1, 31A-30-106.5, 31A-30-106.7, 31A-30-107, and 31A-30-108, apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit.

(7) The commissioner may make rules requiring that the marketing practices be consistent with this chapter for:

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer;

(d) an insurance consultant; and

(e) a navigator.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-30-105. Establishment of classes of business.

Effective January 1, 2014, a covered carrier may establish up to four separate classes of business:

(1) one class of business for individual health benefit plans that are not grandfathered under PPACA;

(2) one class of business for small employer health benefit plans that are not grandfathered under PPACA;

(3) one class of business for individual health benefit plans that are grandfathered under PPACA; and

(4) one class of business for small employer health benefit plans that are grandfathered under PPACA.

Amended by Chapter 341, 2013 General Session

31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans for individuals under this chapter are subject to this section.

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to the individual under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate

except as provided under Subsection (1)(b)(ii).

(ii) A carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the rate manual for the class of business of the carrier offering an individual health benefit plan.

(d) (i) A carrier offering an individual health benefit plan shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical individuals that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the individuals assumed to select particular health benefit products.

(iii) A carrier offering an individual health benefit plan shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(f) A carrier offering a health benefit plan to an individual may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) geographic area; and

(iv) family composition.

(g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) implement this chapter;

(B) assure that rating practices used by carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter; and

(C) promote transparency of rating practices of health benefit plans, except that a carrier may not be required to disclose proprietary information.

(ii) The rules described in Subsection (1)(g)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the

individuals assumed to select particular health benefit products; and

(B) prescribe the manner in which case characteristics may be used by carriers who offer health benefit plans to individuals.

(h) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) A carrier subject to this section shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the carrier is in compliance with this chapter; and

(B) the rating methods of the carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the carrier at the carrier's principal place of business.

(c) A carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Except as provided in Subsection (1)(g) or required by PPACA, a record submitted to the commissioner under this section shall be maintained by the commissioner as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for small employer health benefit plans under this chapter are subject to this section.

(2) (a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to an employer group under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

(3) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the small employer carrier's rate manual for the class of business, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d); and

(c) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined for the class of business from the small employer carrier's rate manual.

(4) (a) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(b) Rating adjustments and factors, including case characteristics, shall be applied uniformly and consistently to the rates charged for all employees and dependents of the small employer.

(c) Rating factors shall produce premiums for identical groups that:

(i) differ only by the amounts attributable to plan design; and

(ii) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(d) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(5) A health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(6) The small employer carrier may not use case characteristics other than the following:

(a) age of the employee, in accordance with Subsection (7);

(b) geographic area;

(c) family composition in accordance with Subsection (9);

(d) for plans renewed or effective on or after July 1, 2011, gender of the employee and spouse;

(e) for an individual age 65 and older, whether the employer policy is primary or

secondary to Medicare; and

(f) a wellness program, in accordance with Subsection (12).

(7) Age limited to:

(a) the following age bands:

(i) less than 20;

(ii) 20-24;

(iii) 25-29;

(iv) 30-34;

(v) 35-39;

(vi) 40-44;

(vii) 45-49;

(viii) 50-54;

(ix) 55-59;

(x) 60-64; and

(xi) 65 and above; and

(b) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (9)(b):

(i) as developed by the commissioner by administrative rule; and

(ii) not to exceed an overall ratio as provided in Subsection (8).

(8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:

(i) 5:1 for plans renewed or effective before January 1, 2012; and

(ii) 6:1 for plans renewed or effective on or after January 1, 2012; and

(b) the age slope ratios for each age band may not overlap.

(9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:

(a) an overall ratio of:

(i) 5:1 or less for plans renewed or effective before January 1, 2012; and

(ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and

(b) a tier rating structure that includes:

(i) four tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a child or children; and

(D) a family, consisting of an employee plus spouse, and a child or children;

(ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children; and

(E) employee plus spouse plus one or more children; or

(iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children;

(E) employee plus spouse plus one child; and

(F) employee plus spouse plus two or more children.

(10) If a health benefit plan is a health benefit plan into which the small employer carrier is no longer enrolling new covered insureds, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the small employer carrier is actively enrolling new covered insureds.

(11) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(12) Notwithstanding Subsection (4)(b), a small employer carrier may:

(a) offer a wellness program to a small employer group if:

(i) the premium discount to the employer for the wellness program does not exceed 20% of the premium for the small employer group; and

(ii) the carrier offers the wellness program discount uniformly across all small employer groups;

(b) offer a premium discount as part of a wellness program to individual employees in a small employer group:

(i) to the extent allowed by federal law; and

(ii) if the employee discount based on the wellness program is offered uniformly across all small employer groups; and

(c) offer a combination of premium discounts for the employer and the employee, based on a wellness program, if:

(i) the employer discount complies with Subsection (12)(a); and

(ii) the employee discount complies with Subsection (12)(b).

(13) (a) Each small employer carrier shall maintain at the small employer carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the small employer carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each small employer carrier shall file with the commissioner on or before April 1 of each year, in a form and manner and containing information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the small employer carrier is in compliance with this chapter; and

(B) the rating methods of the small employer carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (13)(b)(i) shall be retained by the small employer carrier at the small employer carrier's principal place of business.

(c) A small employer carrier shall make the information and documentation described in this Subsection (13) available to the commissioner upon request.

(14) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) implement this chapter; and

(ii) assure that rating practices used by small employer carriers under this section and carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this chapter.

(b) The rules may:

(i) assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans; and

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

(15) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Amended by Chapter 279, 2012 General Session

31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.

(1) Section 31A-30-106 applies to conversion policies.

(2) Conversion policy premium rates may not exceed by more than 35% the index rate for small employers with similar case characteristics for any class of business in which the policy form has been filed.

(3) An insurer may not consider pregnancy of a covered insured in determining its conversion policy premium rates.

Amended by Chapter 284, 2011 General Session

31A-30-106.7. Surcharge for groups changing carriers.

(1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could otherwise charge under Section 31A-30-106.1.

(b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

(i) the change in carriers occurs on the anniversary of the plan year, as defined in Section 31A-1-301;

(ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e);

(iii) employees from an existing group form a new business; and

(iv) the surcharge is not applied uniformly to all similarly situated small groups.

(2) A covered carrier may not impose the surcharge described in Subsection (1) if the offer to cover the group occurs at a time other than the anniversary of the plan year because:

(a) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) the offer to cover the group is not issued until after the anniversary date; or

(b) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) additional underwriting or rating information requested by the covered carrier is not received until after the anniversary date.

(3) If a covered carrier chooses to apply a surcharge under Subsection (1), the application of the surcharge and the criteria for incurring or avoiding the surcharge shall be clearly stated in the:

(a) written application materials provided to the applicant at the time of application; and

(b) written producer guidelines.

(4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to ensure compliance with this section.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a small employer health benefit plan is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if there is no longer any enrollee under the group health plan who lives, resides, or works in:

(i) the service area of the covered carrier; or

(ii) the area for which the covered carrier is authorized to do business; or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's minimum participation requirements.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-30-107.1. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all individuals or dependents; and

(ii) at the option of the individual.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) A health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) the individual no longer lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or

(b) for coverage made available through an association, if:

(i) the individual's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(3) A health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the individual:

(i) performs an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuance in writing:

(I) to each individual provided coverage; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected individuals;

(C) offers to each covered individual on a guaranteed issue basis the option to purchase all other individual health benefit products currently being offered by the covered carrier for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or dependent of a covered individual who may become eligible for coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's health benefit plans in the individual market; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each covered individual; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected individuals;

(C) discontinues and nonrenews all health benefit plans the covered carrier issues or delivers for issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

Amended by Chapter 252, 2003 General Session

31A-30-107.3. Discontinuance and nonrenewal limitations and conditions.

(1) A carrier that elects to discontinue offering all individual health benefit plans under Subsection 31A-30-107.1(3)(e) is prohibited from writing new business in the individual market in this state for a period of five years beginning on the date of discontinuation of the last individual health benefit plan coverage that is discontinued.

(2) A carrier that elects to discontinue offering all small employer health benefit plans under Subsection 31A-30-107(3)(e) is prohibited from writing new business in the small group market in this state for a period of five years beginning on the date of discontinuation of the last small employer coverage that is discontinued.

(3) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier:

(i) may, except as prohibited by Section 31A-30-117, elect to discontinue offering new individual health benefit plans, except to HIPAA eligibles, but shall keep existing individual health benefit plans in effect, except those individual plans that are not renewed under the provisions of Subsection 31A-30-107(2) or 31A-30-107.1(2);

(ii) may elect to continue to offer new individual and small employer health benefit plans; or

(iii) may elect to discontinue all of the covered carrier's health benefit plans in the individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e).

(b) A carrier that makes an election under Subsection (3)(a)(i):

(i) is prohibited from writing new business:

(A) in the individual market in this state; and

(B) for a period of five years beginning on the date of discontinuation;

(ii) may continue to write new business in the small employer market; and

(iii) shall provide written notice of the election under Subsection (3)(a)(i) within two calendar days of the election to the Utah Insurance Department.

(c) The prohibition described in Subsection (3)(b)(i) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(d) A carrier that makes an election under Subsection (3)(a)(iii) is subject to the provisions of Subsection (1).

(4) If a carrier is doing business in one established geographic service area of the state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that geographic service area.

(5) If a small employer employs less than two eligible employees, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows as of the beginning of the

plan year that the employer no longer has at least two current employees.

Amended by Chapter 341, 2013 General Session

31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.

(1) A health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).

(2) (a) In accordance with Subsection (2)(b), an individual carrier:

(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:

(A) a specific physical condition;

(B) a specific disease or disorder; and

(C) any specific or class of prescription drugs; and

(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).

(b) (i) Except as provided in Section 31A-22-630 and Subsection (2)(b)(ii), the following may be the subject of a condition-specific exclusion rider:

(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;

(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius, interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;

(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and sinus related conditions, diseases, and disorders;

(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;

(E) goiter and other thyroid related conditions, diseases, or disorders;

(F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;

(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;

(H) Baker's cyst, ganglion cyst;

(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;

(J) sleep disorders and speech disorders; and

(K) any specific or class of prescription drugs.

(ii) Subsection (2)(b)(i) does not apply:

(A) for the treatment of asthma; or

(B) when the condition is due to cancer.

(iii) A condition-specific exclusion rider:

(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;

(B) may not extend to any secondary medical condition; and

(C) shall include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition, disease, or disorder."

(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.

(d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6(7).

(3) Notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:

(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation period;

(b) the limitation period does not exceed 12 months;

(c) the limitation period is applied uniformly; and

(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).

Amended by Chapter 297, 2011 General Session

31A-30-108. Eligibility for small employer and individual market.

(1) (a) A small employer carrier shall accept a small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec. 2702.

(b) An individual carrier shall accept an individual that applies for individual coverage as set forth in PPACA, Sec. 2702.

(2) (a) A small employer carrier shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) A small employer carrier may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

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Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-30-112. Employee participation levels.

(1) (a) For purposes of this section, "participation" is as defined in Section 31A-1-301.

(b) Except as provided in Subsection (2) and Section 31A-30-206, a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including a participation requirement and a minimum employer contribution requirement, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(2) A covered carrier may not increase a participation requirement or a requirement for minimum employer contribution, applicable to a small employer, at any time after the small employer is accepted for coverage.

Amended by Chapter 341, 2013 General Session

31A-30-114. Disclosure.

(1) A covered carrier shall make the information described in Subsection (2) available:

(a) to:

(i) a small employer; or

(ii) an individual; and

(b) (i) at the time of solicitation; or

(ii) upon the request of:

(A) a small employer; or

(B) an individual;

(c) as part of the covered carrier's solicitation and sales materials.

(2) The following information is required to be disclosed or made available under Subsection (1):

(a) the provisions of the coverage concerning the covered carrier's right to change premium rates; and

(b) the factors that may effect changes in premium rates;

(c) the provisions of the coverage relating to renewability of coverage; and

(d) the provisions of the coverage relating to any preexisting condition exclusion.

Enacted by Chapter 308, 2002 General Session

31A-30-115. Actuarial review of health benefit plans.

(1) (a) The department shall conduct an actuarial review of rates submitted by a carrier that offers a small employer plan and a carrier that offers an individual plan under this chapter:

(i) to verify the validity of the rates, risk factors, and premiums of the plans; and

(ii) as the department determines is necessary to oversee market conduct.

(b) The actuarial review by the department shall be funded from a fee:

(i) established by the department in accordance with Section 63J-1-504; and

(ii) paid by a carrier offering a health benefit plan subject to this chapter.

(c) The department shall:

(i) report aggregate data from the actuarial review to the risk adjuster board created in Section 31A-42-201; and

(ii) contact carriers, if the department determines it is appropriate, to:

(A) inform a carrier of the department's findings regarding the rates of a particular carrier; and

(B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

(d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

(2) (a) There is created in the General Fund a restricted account known as the "Health Insurance Actuarial Review Restricted Account."

(b) The Health Insurance Actuarial Review Restricted Account shall consist of money received by the commissioner under this section.

(c) The commissioner shall administer the Health Insurance Actuarial Review Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the actuarial review conducted by the department under this section.

Amended by Chapter 319, 2013 General Session
Amended by Chapter 341, 2013 General Session

31A-30-116. Essential health benefits.

(1) For purposes of this section, the "Affordable Care Act" is as defined in Section 31A-2-212 and includes federal rules related to the offering of essential health benefits.

(2) The state chooses to designate its own essential health benefits rather than accept a federal determination of the essential health benefits required to be offered in the individual and small group market for plans renewed or offered on or after January 1, 2014.

(3) (a) Subject to Subsections (3)(b) and (c), to the extent required by the Affordable Care Act, and after considering public testimony, the Legislature's Health System Reform Task Force shall recommend to the commissioner, no later than September 1, 2012, a benchmark plan for the state's essential health benefits based on:

(i) the largest plan by enrollment in any of the three largest small employer group insurance products in the state's small employer group market;

(ii) any of the largest three state employee health benefit plans by enrollment;

(iii) the largest insured commercial non-Medicaid health maintenance organization operating in the state; or

(iv) other benchmarks required or permitted by the Affordable Care Act.

(b) Notwithstanding the provisions of Subsection 63M-1-2505.5(2), based on the

recommendation of the task force under Subsection (3)(a), and within 30 days of the task force recommendation, the commissioner shall adopt an emergency administrative rule that designates the essential health benefits that shall be included in a plan offered or renewed on or after January 1, 2014, in the small employer group and individual markets.

(c) The essential health benefit plan:

(i) shall not include a state mandate if the inclusion of the state mandate would require the state to contribute to premium subsidies under the Affordable Care Act; and

(ii) may add benefits in addition to the benefits included in a benchmark plan described in Subsection (3)(b) if the additional benefits are mandated under the Affordable Care Act.

Enacted by Chapter 279, 2012 General Session

31A-30-117. Patient Protection and Affordable Care Act -- Market transition.

(1) (a) After complying with the reporting requirements of Section 63M-1-2505.5, the commissioner may adopt administrative rules that change the rating and underwriting requirements of this chapter as necessary to transition the insurance market to meet federal qualified health plan standards and rating practices under PPACA.

(b) Administrative rules adopted by the commissioner under this section may include:

(i) the regulation of health benefit plans as described in Subsections 31A-2-212(5)(a) and (b); and

(ii) disclosure of records and information required by PPACA and state law.

(c) (i) The commissioner shall establish by administrative rule one statewide open enrollment period that applies to the individual insurance market that is not on the PPACA certified individual exchange.

(ii) The statewide open enrollment period:

(A) may be shorter, but no longer than the open enrollment period established for the individual insurance market offered in the PPACA certified exchange; and

(B) may not be extended beyond the dates of the open enrollment period established for the individual insurance market offered in the PPACA certified exchange.

(2) A carrier that offers health benefit plans in the individual market that is not part of the individual PPACA certified exchange:

(a) shall open enrollment:

(i) during the statewide open enrollment period established in Subsection (1)(c); and

(ii) at other times, for qualifying events, as determined by administrative rule adopted by the commissioner; and

(b) may open enrollment at any time.

(3) To the extent permitted by the Centers for Medicare and Medicaid Services policy, or federal regulation, the commissioner shall allow a health insurer to choose to continue coverage and individuals and small employers to choose to re-enroll in

coverage in nongrandfathered health coverage that is not in compliance with market reforms required by PPACA.

Amended by Chapter 425, 2014 General Session

31A-30-118. Patient Protection and Affordable Care Act -- State insurance mandates -- Cost of additional benefits.

(1) (a) The commissioner shall identify a new mandated benefit that is in excess of the essential health benefits required by PPACA.

(b) The state shall quantify the cost attributable to each additional mandated benefit specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost associated with the mandated benefit, which shall be:

(i) calculated in accordance with generally accepted actuarial principles and methodologies;

(ii) conducted by a member of the American Academy of Actuaries; and

(iii) reported to the commissioner and to the individual exchange operating in the state.

(c) The commissioner may require a proponent of a new mandated benefit under Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance with Subsection (1)(b). The commissioner may use the cost information provided under this Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

(2) If the state is required to defray the cost of additional required benefits under the provisions of 45 C.F.R. 155.170:

(a) the state shall make the required payments:

(i) in accordance with Subsection (3); and

(ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

(b) an issuer of a qualified health plan that receives a payment under the provisions of Subsection (1) and 45 C.F.R. 155.170 shall:

(i) reduce the premium charged to the individual on whose behalf the issuer will be paid under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); or

(ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an individual on whose behalf the issuer received a payment under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); and

(c) a premium rebate made under this section is not a prohibited inducement under Section 31A-23a-402.5.

(3) A payment required under 45 C.F.R. 155.170(c) shall:

(a) unless otherwise required by PPACA, be based on a statewide average of the cost of the additional benefit for all issuers who are entitled to payment under the provisions of 45 C.F.R. 155.70; and

(b) be submitted to an issuer through a process established and administered by:

(i) the federal marketplace exchange for the state under PPACA for individual health plans; or

(ii) Avenue H small employer market exchange for qualified health plans offered on the exchange.

(4) The commissioner:

(a) may adopt rules as necessary to administer the provisions of this section and 45 C.F.R. 155.170; and

(b) may not establish or implement the process for submitting the payments to an issuer under Subsection (3)(b)(i) unless the cost of establishing and implementing the process for submitting payments is paid for by the federal exchange marketplace.

Enacted by Chapter 425, 2014 General Session

31A-30-201. Title.

This part is known as "Defined Contribution Arrangements."

Enacted by Chapter 12, 2009 General Session

31A-30-202. Definitions.

For purposes of this part:

(1) "Defined benefit plan" means an employer group health benefit plan in which:

(a) the employer selects the health benefit plan or plans from a single insurer;

(b) employees are not provided a choice of health benefit plans on the Health Insurance Exchange; and

(c) the employer is subject to contribution requirements in Section 31A-30-112.

(2) "Defined contribution arrangement":

(a) means a defined contribution arrangement employer group health benefit plan that:

(i) complies with this part; and

(ii) is sold through the Health Insurance Exchange in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act; and

(b) beginning January 1, 2011, includes an employer choice of either a defined contribution arrangement health benefit plan or a defined benefit plan offered through the Health Insurance Exchange.

(3) "Health reimbursement arrangement" means an employer provided health reimbursement arrangement in which reimbursements for medical care expenses are excluded from an employee's gross income under the Internal Revenue Code.

(4) "Producer" is as defined in Subsection 31A-23a-501(4)(a).

(5) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies under Section 125, Internal Revenue Code, which permits an employee to contribute pre-tax dollars to a health benefit plan.

(6) "Small employer" is defined in Section 31A-1-301.

Amended by Chapter 68, 2010 General Session

31A-30-202.6. Dental and vision plans on the defined contribution arrangement market.

(1) Beginning January 1, 2014, a carrier may offer dental and vision plans in the defined contribution arrangement market.

(2) (a) A carrier that offers a dental or vision plan in the defined contribution arrangement market is not required to offer the same dental or vision plans outside the defined contribution arrangement market and does not have to use the same rating and underwriting practices in and out of the defined contribution arrangement market.

(b) If a carrier offers a dental or vision plan in the defined contribution arrangement market, the carrier shall allow an employee of a small employer group to enroll in a dental and vision plan in accordance with Subsection (3).

(3) (a) A small employer group shall participate in a defined contribution arrangement and meet participation requirements for the defined contribution arrangement before the employer may elect to offer its employees dental or vision plans under Subsection (3)(b).

(b) A small employer who meets the requirements of Subsection (3)(a) may elect to offer its employees:

(i) a dental plan offered in the defined contribution arrangement market;

(ii) a vision plan offered in the defined contribution arrangement market; or

(iii) both a vision plan and a dental plan offered in the defined contribution arrangement market.

(4) An employee whose employer has offered its employees a defined contribution medical plan and met participation requirements under Subsection (3)(a) may elect to enroll, or not enroll, in the dental and vision plan selected by the employer.

(5) An employer's small group must meet participation requirements established by the commissioner by administrative rule for each dental or vision plan selected by an employer under Subsection (3).

Enacted by Chapter 341, 2013 General Session

31A-30-203. Eligibility for defined contribution arrangement market -- Enrollment.

(1) (a) An eligible small employer may choose to participate in:

(i) the defined contribution arrangement market in the Health Insurance Exchange under this part; or

(ii) the traditional defined benefit market under Part 1, Individual and Small Employer Group.

(b) A small employer may choose to offer its employees one of the following through the defined contribution arrangement market in the Health Insurance Exchange:

(i) a defined contribution arrangement health benefit plan; or

(ii) a defined benefit plan.

(c) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer.

(2) (a) Participating insurers shall offer to accept all eligible employees of an employer described in Subsection (1), and their dependents, at the same level of benefits as anyone else who has the same health benefit plan in the defined contribution arrangement market on the Health Insurance Exchange.

(b) A participating insurer may:

(i) request an employer to submit a copy of the employer's quarterly wage list to determine whether the employees for whom coverage is provided or requested are bona fide employees of the employer; and

(ii) deny or terminate coverage if the employer refuses to provide documentation requested under Subsection (2)(b)(i).

Amended by Chapter 400, 2011 General Session

31A-30-204. Employer election -- Defined benefit -- Defined contribution arrangements -- Responsibilities.

(1) (a) An employer participating in the defined contribution arrangement market on the Health Insurance Exchange shall make an initial election to offer its employees either a defined benefit plan or a defined contribution arrangement health benefit plan.

(b) If an employer elects to offer a defined benefit plan:

(i) the employer or the employer's producer shall enroll the employer in the Health Insurance Exchange;

(ii) the employees shall submit the uniform application required for the Health Insurance Exchange; and

(iii) the employer shall select the defined benefit plan in accordance with Section 31A-30-208.

(c) When an employer makes an election under Subsections (1)(a) and (b):

(i) the employer may not offer its employees a defined contribution arrangement health benefit plan; and

(ii) the employees may not select a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(d) If an employer elects to offer its employees a defined contribution arrangement health benefit plan, the employer shall comply with the provisions of Subsections (2) through (5).

(2) (a) (i) An employer that chooses to participate in a defined contribution arrangement health benefit plan may not offer to an employee a health benefit plan that is not a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(ii) Subsection (2)(a)(i) does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts for health care expenses.

(b) (i) To the extent permitted by Sections 31A-1-301, 31A-30-112, and 31A-30-206, and the risk adjustment plan adopted under Section 31A-42-204, the employer reserves the right to determine:

(A) the criteria for employee eligibility, enrollment, and participation in the employer's health benefit plan; and

(B) the amount of the employer's contribution to that plan.

(ii) The determinations made under Subsection (2)(b) may only be changed during periods of open enrollment.

(3) An employer that chooses to establish a defined contribution arrangement health benefit plan to provide a health benefit plan for its employees shall:

(a) establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the Health Insurance Exchange created in Section 63M-1-2504, which may include:

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

(iii) another plan or arrangement similar to Subsection (3)(a)(i) or (ii) which is excluded or deducted from gross income under the Internal Revenue Code;

(b) before the employee's health benefit plan selection period:

(i) inform each employee of the health benefit plan the employer has selected as the default health benefit plan for the employer group;

(ii) offer each employee a choice of any of the defined contribution arrangement health benefit plans available through the defined contribution arrangement market on the Health Insurance Exchange; and

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, before the employee's selection period ends:

(A) selects a different defined contribution arrangement health benefit plan available in the Health Insurance Exchange;

(B) provides proof of coverage from another health benefit plan; or

(C) specifically declines coverage in a health benefit plan.

(4) An employer shall enroll an employee in the default defined contribution arrangement health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection (3)(b)(iii) before the end of the employee selection period, which may not be less than 14 calendar days.

(5) The employer's notice to the employee under Subsection (3)(b)(iii) shall inform the employee that the failure to act under Subsections (3)(b)(iii)(A) through (C) is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

Amended by Chapter 68, 2010 General Session

31A-30-206. Minimum participation and contribution levels -- Premium payments.

An insurer who offers a health benefit plan for which an employer has established a defined contribution arrangement under the provisions of this part:

(1) may not:

(a) establish an employer minimum contribution level for the health benefit plan premium under Section 31A-30-112, or any other law; or

(b) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to maintain a minimum employer contribution level;

(2) shall accept premium payments for an enrollee from multiple sources through the Internet portal, including:

(a) government assistance programs;

(b) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by any employer of the enrollee;

(c) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by an employer of a spouse or dependent of the enrollee; and

(d) contributions from private sources of premium assistance; and

(3) may require, as a condition of coverage, a minimum participation level for eligible employees of an employer, which for purposes of the defined contribution arrangement market may not exceed 75% participation.

Amended by Chapter 297, 2011 General Session

31A-30-207. Rating and underwriting restrictions for health plans in the defined contribution arrangement market.

(1) Except as provided in Subsection (2), rating and underwriting restrictions for defined contribution arrangement health benefit plans offered in the Health Insurance Exchange shall be in accordance with Section 31A-30-106.1, and the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act.

(2) Notwithstanding Subsections 31A-30-106.1(9)(b)(ii) and (iii), a carrier offering a defined contribution arrangement in the Health Insurance Exchange under this part shall calculate rates based on a family tier rating structure that includes four tiers in compliance with Subsection 31A-30-106.1(9)(b)(i).

(3) All insurers who participate in the defined contribution market shall:

(a) participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

(b) provide the risk adjuster board with:

(i) an employer group's risk factor; and

(ii) carrier enrollment data; and

(c) submit rates to the exchange that are net of commissions.

(4) When an employer group enters the defined contribution arrangement market and the employer group has a health plan with an insurer who is participating in the defined contribution arrangement market, the risk factor applied to the employer group when it enters the defined contribution arrangement market may not be greater than the employer group's renewal risk factor for the same group of covered employees and the same effective date, as determined by the employer group's insurer.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-30-208. Enrollment for defined contribution arrangements.

(1) An insurer offering a health benefit plan in the defined contribution arrangement market:

(a) shall allow an employer to enroll in a small employer defined contribution arrangement plan; and

(b) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) (a) An insurer may enter or exit the defined contribution arrangement market on January 1 of each year.

(b) An insurer may offer new or modify existing products in the defined contribution arrangement market:

(i) on January 1 of each year;

(ii) when required by changes in other law; and

(iii) at other times as established by the risk adjuster board created in Section 31A-42-201.

(c) An insurer shall give the department, the Health Insurance Exchange, and the risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a) or (b).

Amended by Chapter 319, 2013 General Session
Amended by Chapter 341, 2013 General Session

31A-30-209. Insurance producers and the Health Insurance Exchange.

(1) A producer may be listed on the Health Insurance Exchange as a credentialed producer if the producer is designated as a credentialed agent for the Health Insurance Exchange in accordance with Subsection (2).

(2) A producer whose license under this title authorizes the producer to sell accident and health insurance may be credentialed by the Health Insurance Exchange and may sell any product on the Health Insurance Exchange, if the producer:

(a) is an appointed producer with:

(i) all carriers that offer a plan in the defined contribution market on the Health Insurance Exchange; and

(ii) at least one carrier that offers a dental plan on the Health Insurance Exchange; and

(b) completes each year the Health Insurance Exchange training that includes training on premium assistance programs.

(3) A carrier shall appoint a producer to sell the carrier's products in the defined contribution arrangement market of the Health Insurance Exchange, within 30 days of the notice required in Subsection (3)(b), if:

(a) the producer is currently appointed by a majority of the carriers in the Health Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange; and

(b) the producer informs the carrier that the producer is:

(i) applying to be appointed to the defined contribution arrangement market in the Health Insurance Exchange;

(ii) appointed by a majority of the carriers in the defined contribution arrangement market in the Health Insurance Exchange;

(iii) willing to complete training regarding the carrier's products offered on the defined contribution arrangement market in the Health Insurance Exchange; and

(iv) willing to sign the contracts and business associate's agreements that the carrier requires for appointed producers in the Health Insurance Exchange.

Amended by Chapter 290, 2014 General Session

Amended by Chapter 300, 2014 General Session

31A-30-210. State contract requirements -- Employer default plans.

(1) This section applies to an employer who is required to offer its employees a health benefit plan as a condition of qualifying for a state contract under:

(a) Section 17B-2a-818.5;

(b) Section 19-1-206;

(c) Subsection 63A-5-205(3);

(d) Section 63C-9-403;

(e) Section 72-6-107.5; and

(f) Section 79-2-404.

(2) An employer described in Subsection (1) shall, when selecting the default plan required in Section 31A-30-204, select a default plan that is "qualified health insurance coverage" as defined in the sections listed in Subsections (1)(a) through (f).

Enacted by Chapter 229, 2010 General Session

31A-30-211. Insurer disclosure.

(1) (a) A carrier shall provide an employer and the employer's producer with premium renewal rates at least 60 days before the group's renewal date for a plan offered under Part 1, Individual and Small Employer Group.

(b) The Health Insurance Exchange shall provide an employer and the employer's producer with premium renewal rates at least 60 days before the group's renewal date for a plan offered under Part 2, Defined Contribution Arrangements.

(2) An insurer does not have to provide additional notice of premium renewal rates to the employer or the employer's producer if the Health Insurance Exchange provides notice in accordance with Subsection (1)(b).

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-30-301. Title.

This part is known as the "Individual and Small Employer Risk Adjustment Act."

Enacted by Chapter 425, 2014 General Session

31A-30-302. Creation of state risk adjustment program.

(1) The commissioner shall convene a group of stakeholders and actuaries to assist the commissioner with the evaluation or the risk adjustment options described in Subsection (2). If the commissioner determines that a state-based risk adjustment program is in the best interest of the state, the commissioner shall establish an individual and small employer market risk adjustment program in accordance with 42 U.S.C. 18063 and this section.

(2) The risk adjustment program adopted by the commissioner may include one of the following models:

(a) continue the United States Department of Health and Human Services

administration of the federal model for risk adjustment for the individual and small employer market in the state;

(b) have the state administer the federal model for risk adjustment for the individual and small employer market in the state;

(c) establish and operate a state-based risk adjustment program for the individual and small employer market in the state; or

(d) another risk adjustment model developed by the commissioner under Subsection (1).

(3) Before adopting one of the models described in Subsection (2), the commissioner:

(a) may enter into contracts to carry out the services needed to evaluate and establish one of the risk adjustment options described in Subsection (2); and

(b) shall, prior to October 30, 2014, comply with the reporting requirements of Section 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options described in Subsection (2).

(4) The commissioner may:

(a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that require an insurer that is subject to the state-based risk adjustment program to submit data to the all payers claims database created under Section 26-33a-106.1; and

(b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act, to cover the ongoing administrative cost of running the state-based risk adjustment program.

Enacted by Chapter 425, 2014 General Session

31A-30-303. Enterprise fund.

(1) There is created an enterprise fund known as the Individual and Small Employer Risk Adjustment Enterprise Fund.

(2) The following funds shall be credited to the fund:

(a) appropriations from the General Fund;

(b) fees established by the commissioner under Section 31A-30-302;

(c) risk adjustment payments received from insurers participating in the risk adjustment program; and

(d) all interest and dividends earned on the fund's assets.

(3) All money received by the fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The fund shall comply with Title 63A, Utah Administrative Services Code.

(6) The fund shall be used to implement and operate the risk adjustment program created by this part.

Enacted by Chapter 425, 2014 General Session